

APPENDIX 5C

PRIOR AUTHORIZATION REQUEST FORM (PA/RF)
EVALUATION AND TESTING

MAIL TO:

E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF

(DO NOT WRITE IN THIS SPACE)

ICN #

A.T. #

P.A. # 0123456

1 PROCESSING TYPE

126

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER

1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)

Recipient, Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)

609 Willow
Anytown, WI 55555

5 DATE OF BIRTH

MM/DD/YY

6 SEX

M

☐

F

☒

8 BILLING PROVIDER TELEPHONE NUMBER

(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE.

Non Board-Operated Outpatient Psychotherapy Clinic
1 West Williams
Anytown, WI XXXXX

9 BILLING PROVIDER NO.

12345678

10 DX: PRIMARY

11 DX: SECONDARY

12 START DATE OF SOL

N/A

13 FIRST DATE RX

N/A

14	PROCEDURE CODE	15	MOD	16	POS	17	TOS	18	DESCRIPTION OF SERVICE	19	OR	20	CHARGES
	90801				3		9		Psych diagnostic interview/exam including history		2 hrs.		XXX.XX

22. An approved authorization does not guarantee payment.

Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAF reimbursement will be allowed only if the service is not covered by the HMO.

TOTAL CHARGE

21

XXX.XX

23 MM/DD/YY
DATE

24 I.M. Provider, Ph.D.
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐
APPROVED

☐
MODIFIED

☐
DENIED

☐
RETURN

- REASON:

- REASON:

- REASON:

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED